MDR Tracking Number: M5-04-0693-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-4-03.

The IRO reviewed office visits, joint mobilization, manual traction/manual therapy techniques, therapeutic exercises, and myofascial release from 7-25-03 to 8-15-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-14-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
7-28-03	99080-73	$15.00	$0.00	F	$15.00	Rules 134.307(g)(3) (A-F) & 129.5	Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
8-1-03 8-4-03 8-6-03 8-8-03	99213	$65.14 x 4 days	$0.00		$54.59 x 125% = $68.24	Medicare Fee Schedule & Rule 134.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of $65.14 x 4 = $260.56.
8-1-03	97140	$31.58	$30.65		$27.30 x 125% = $34.13		Relevant information supports delivery of service. Recommend additional reimbursement of $ .93.

8-8-03	97110 (4 units)	$135.50	$127.58		$29.59 per unit x 125% = $36.99 x 4 units = $147.96		Relevant information supports delivery of service. Recommend additional reimbursement of $7.92.
8-15-03	99213	$66.19	$0.00	No EOB	$54.59 x 125% = $68.24		Since neither party submitted an EOB, this review will be per the 2002 MFG. Relevant information supports delivery of service. Recommend reimbursement of $66.19.
TOTAL		$443.69	$158.23				The requestor is entitled to reimbursement of $335.60.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 8-1-03 through 8-15-03 in this dispute.

This Order is hereby issued this 24th day of May 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 11, 2004

Re: IRO Case # M5-04-0693-01 Amended

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured his right knee in ___ when he slipped on a ladder. He was treated with physical therapy for several weeks with poor results. He then changed treating doctors. An MRI and electodiagnostic studies were performed, and the patient was treated with medication, physical therapy, chiropractic care and surgery on 9/23/03.

Requested Service(s)
Office visit, joint mobilization, myofascial release, manual traction, exercises, physical performance testing 7/25/03-8/15/03

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
The patient had several weeks of conservative therapy with poor results prior to the treatment in dispute. The patient had a fair trial of conservative therapy that failed. The treating DC should have referred the patient to an orthopedic surgeon instead of initiating further conservative treatment, which also failed to be beneficial.
In a 6/6/03 report ACL reconstruction was recommended because of the amount of ligament laxity and pain that the patient had, yet further therapy continued for months with poor results until surgery was performed on 9/23/03. Additional non-effective therapy was not medically necessary, especially when surgery was recommended.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.